

# STRATEGIES FOR HELPING DEPRESSED MEN WITH SEXUAL DYSFUNCTION

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## ABSTRACT

Sexual dysfunction may be an early symptom of depression with drug treatment contributing to the problem. It can also arise from the impact of the illness on the patient or on the relationship. Sexual dysfunction is a common adverse effect of antidepressants that frequently results in treatment non-compliance. Avoidance of sexual issues is seen in clinical settings, and is often related to both clinician's and patient's anxiety about the topic. Strategies for managing antidepressant induced sexual dysfunction are discussed.

**Keywords:** depression, sexual dysfunction, erectile dysfunction, selective serotonin reuptake inhibitors, sex therapy

Sexual dysfunction (SD) in men is common. Tan et al (2003) studied the prevalence of erectile dysfunction in Singapore males aged 30 and above, and found that 51% of respondents reported some degree of erectile dysfunction<sup>1</sup>. A large study in the United States with a sample of 1410 men found a 31% 12-month prevalence of SD<sup>2</sup>. Existing studies report wide discrepancies with regard to the association between depression and loss of desire, ranging between 31% and 77% in untreated patients<sup>3</sup>. In one study, a group of depressed patients, prior to initiation of therapy, had an incidence of erectile dysfunction of 35%, and decreased libido of 31%<sup>4</sup>.

SD and depression can be related in several ways. SD may be an early symptom of depression with drug therapy contributing to the problem or can arise from the impact of the illness on the patient or the relationship<sup>5</sup>. Depression can be expressed by withdrawal from sex or by a hostile insistence on sex that pushes a partner away<sup>6</sup>. Increased sexual desire seen in recovery from depression may often be hidden as a result of drug-induced SD.

A recent landmark study of 152 men with untreated minor depression and concomitant erectile dysfunction examined the effect of sildenafil<sup>7</sup>. Regardless of the treatment (sildenafil or placebo), in those patients who were deemed responders (defined as having improved erections), there was a clinically significant improvement in depression parameters. This would imply that, in these patients, depression was most likely secondary to the erectile dysfunction. The study also demonstrated that successful treatment of erectile dysfunction can result in improvement in both sexual and nonsexual (whole life, relationship with partner, social contacts with friends and leisure situations) aspects of quality of life.

## Barriers to diagnosis of SD

Avoidance of discussing sexual issues is encountered in clinical settings, and is often related to both clinician's and patient's anxiety about the topic. Clinicians sometimes avoid taking a detailed sexual history for fear of increasing the distress of patients and/or because they feel unqualified to deal with the content. Age of the patient, gender difference, sexual orientation and cultural factors could also contribute to the reluctance of taking an adequate sexual history<sup>8</sup>. It is important for clinicians to determine if they have any beliefs or attitudes about sexuality that might inhibit open and thorough discussion of intimate matters. Possible starting points for communication about sexuality in family practice include the prescription of drugs that trigger sexual disorders, diagnosis of conditions that are associated with sexual problems, and the patients' personal, social, and occupational background<sup>9</sup>.

The following are causes of SD in patients with major depression:

1. SD as a manifestation of depression
2. Comorbid medical illness
3. Comorbid psychiatric disorder
4. Hormonal factors
5. Psychosocial factors
6. Primary SD (e.g., developmental issues, sexual trauma)
7. Medication side effect.

## Medication side effect

SD is a common adverse effect of antidepressants that frequently results in treatment non-compliance. Tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs), have all been implicated in erection failure. The action is presumed secondary to blockade at the serotonin and possibly alpha-adrenergic receptors. Also, serotonin may centrally inhibit orgasm and has a relaxing effect on peripheral smooth muscle, so inhibiting orgasm contractions. The range of antidepressant induced SD is extensive: decreased libido, erection failure, decreased lubrication, decreased engorgement, delayed ejaculation, diminished intensity and absent orgasm have been described.

All SSRIs are known to cause SD. In men, they cause lowering of libido, difficulty maintaining an erection, and delayed/absent orgasm. Women receiving SSRIs may develop decreased desire, decreased arousal, decreased genital sensation, and difficulty achieving orgasm. These side effects could be the result of enhanced serotonergic activity, as evidenced by the fact that SSRI induced anorgasmia can be

ameliorated by serotonin antagonist cyproheptadine. Lithium carbonate, used to treat bipolar depression, can also decrease libido and interfere with erections, perhaps because of decreased central dopamine activity.

In clinical management of depressive disorders, it would be prudent to choose an initial antidepressant wisely, paying special attention to issues pertaining to safety, efficacy, and tolerability. Antidepressants with low or no SD, and which are available locally, include mirtazapine and moclobemide.

### Strategies for managing anti-depressant induced sexual dysfunction

The following options can be considered:

1. Wait for adaptation to occur  
Adaptation to sexual side effects is rare. It occurs when initial complaints are mild, most often when they are associated with delayed orgasm, rather than libido or arousal complaints. If sexual side effect does not abate within 4–6 months, it is likely to persist unless other strategies are used
2. Lower the dose of antidepressant  
Reduction to minimal effective dose risks sub-therapeutic antidepressant dose, and resultant relapse
3. Consider drug holiday  
The advantage of this strategy is that there are no additional medications used. However, patients may experience symptoms of SSRI withdrawal, and there are risks of treatment failure
4. Substitute another drug  
In this strategy, an alternative antidepressant is used. There is the fear of therapeutic failure
5. Use pharmacologic antidotes  
Sildenafil has been reported to reverse sexual side effects of several antidepressants in both men and women <sup>(10,11)</sup>. It may be effective on an 'as needed' basis, with doses ranging from 50 to 100 mg 30 to 60 minutes prior to sexual activity. Good success rates have been reported. Disadvantages of this strategy are possibility of side effects and increased cost.

Ultimately, management of SD requires clever use of adjuvant agents to counter side effects or clever choice of a single well tolerated first line agent. In managing the depressed patients with SD, one would need to bear the following pointers in mind:

1. Counsel patients to adopt healthy lifestyle
2. Assess relationship harmony & commitment
3. In patients who smoke or abuse alcohol, advice should be given regarding the effect of nicotine as well as alcohol on erectile dysfunction
4. Lose weight (for persons who are obese)
5. Removing TV from bedroom may help in some cases
6. Address acute or chronic psychological factors (e.g., stress, fatigue, insomnia).

For more complex cases, sex therapy would be useful in teasing out important history, educating the patient and partner, resolving the sexual difficulty, suggesting sexual enhancement techniques and helping couples resolve relationship problems. There are two main approaches in the psychological treatment of SD. One approach focuses upon the patient's sexual symptom directly and attempts to resolve sexual dysfunction by using a combination of prescribed sexual activities ('homework assignments') and psychotherapy. The other approach includes marital/couples therapy, which places the patient's sexual problems in the context of more extensive intrapsychic and interpersonal issues. Very often, in clinical practice, a combination of pharmacologic and psychosocial interventions is used.

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